



**Patient & Responsible Party Information...part 1**

**Patient's complete legal name** \_\_\_\_\_  
*(should match your legal ID = License/Passport)*      LAST                              FIRST                              MIDDLE INITIAL      JR, SR, ETC

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Sex:** Male    Female

**\*Social Security #**XXX-XX-\_\_\_\_ **\*last 4 digits only**

**Home phone** (\_\_\_\_)\_\_\_\_-\_\_\_\_      **Cell phone** (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Address**\_\_\_\_\_ **City**\_\_\_\_\_ **State**\_\_\_\_ **Zip**\_\_\_\_\_

**Marital Status** *(Please circle one)*    Single    Married    Divorced    Legally Separated    Widowed

**Patient's Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Employment address**\_\_\_\_\_ **City**\_\_\_\_\_ **State**\_\_\_\_ **Zip**\_\_\_\_\_

**Phone** (\_\_\_\_)\_\_\_\_-\_\_\_\_

**If retired**, please provide date this occurred: \_\_\_\_\_

**If disabled**, please provide date this occurred: \_\_\_\_\_

**If you are MARRIED, please provide...** Spouse's complete name: \_\_\_\_\_

Spouse's employer \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

Spouse's phone # at work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Please provide an emergency contact person who does not live with you:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone number (\_\_\_\_)\_\_\_\_-\_\_\_\_ Alternate number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

\*\*\*\*\*  
**My signature below verifies that the information provided on this document is accurate as of today's date:**

**Patient's PRINTED name:** \_\_\_\_\_

ACCOUNT# \_\_\_\_\_  
\*\*\*FOR OFFICE USE ONLY\*\*\*

**SIGNATURE OF:** **(PLEASE CIRCLE)** Patient / Parent / Guardian / Patient Advocate

**Date** \_\_\_\_\_

Patient & Responsible Party Information...part 2

▶ Please  check the appropriate box(es) and provide complete information as it applies

**I AM MY OWN GUARDIAN** and do not require or enlist any other party to sign on my behalf in decisions relative to healthcare.

**THE PATIENT IS UNDER 18 YEARS OF AGE:** parent / guardian must complete the following, provide legal identification, and accompany the patient to all appointments:

Mother's Name (first & last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Mother's Employer \_\_\_\_\_ Phone # at work (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
 Father's Name (first & last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Father's Employer \_\_\_\_\_ Phone # at work (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
 Other: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone # at work: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Cell / Alternate Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

**THE PATIENT HAS A COURT APPOINTED LEGAL GUARDIAN: A VALID COPY OF THE DOCUMENTATION INDICATING SUCH MUST BE PROVIDED, and THE RESPONSIBLE PARTY INDICATED MUST PROVIDE LEGAL IDENTIFICATION, ACCOMPANY THE PATIENT TO ALL APPOINTMENTS AND SIGN ALL DOCUMENTS RELATIVE TO THE PATIENT'S HEALTHCARE DECISIONS.**

**THE PATIENT HAS A PATIENT ADVOCATE / POWER OF ATTORNEY: A VALID COPY OF THE DOCUMENTATION INDICATING SUCH MUST BE PROVIDED, and THE RESPONSIBLE PARTY INDICATED MUST PROVIDE LEGAL IDENTIFICATION AND ACCOMPANY THE PATIENT TO ALL APPOINTMENTS, UNLESS OTHERWISE NOTED IN THE DOCUMENTATION.**

Name of Legal Guardian / Power of Attorney: \_\_\_\_\_  
 Phone number (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Alternate Phone number (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**THE PATIENT RESIDES IN AN EXTENDED CARE FACILITY / NURSING HOME / ETC.**

Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Name of physician on-staff there? \_\_\_\_\_

**\*\*\*THIS PHYSICIAN'S INFORMATION MUST BE PROVIDED ON THE CORRESPONDENCE PAGE**

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**My signature below verifies that the information provided on this document is accurate as of today's date:**

Patient's PRINTED name: \_\_\_\_\_

<b>ACCOUNT#</b> _____ <small>***FOR OFFICE USE ONLY***</small>
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**SIGNATURE OF:** (PLEASE CIRCLE) Patient / Parent / Guardian / Patient Advocate \_\_\_\_\_ Date \_\_\_\_\_